Within corporate limit

Dr Fred Wms

M

08800

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1414 Bedford St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 1414 Bedford St.

3. NAME OF DECEASED (Type or Print) (First) Mrs Mary (Middle) Ellen (Last) Bradour

4. DATE OF DEATH (Month) Sept (Day) 9 (Year) 1950

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH April 22, 1868

9. AGE last birthday 82 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Wellersburg Pa

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Peter Knieriem

14. MOTHER'S MAIDEN NAME Rebecca Emerick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Guy Bradour - 1414 Bedford St City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocardial

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Degeneration

(c)

INTERVAL BETWEEN ONSET AND DEATH ?

422.2

93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-25-, 1950, to 9-9-, 1950, that I last saw the deceased alive on 9-9-, 1950, and that death occurred at 9:15 P m., from the causes and on the date stated above.

SIGNATURE W. L. Williams (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 9-11-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Sept 12, 1950

NAME OF CEMETERY OR CREMATORY St Lukes Lutheran Cem.

LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Sept 2, 1950

REGISTRAR'S SIGNATURE Winter R Frantz, M.D.

24. FUNERAL DIRECTOR John J Hofer Cumberland ADDRESS Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
SEP 19 1950
BUREAU V. S

Within corpo... DR. W.F. WILLIAMS

08801

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; LENGTH OF STAY (in this place) 20 DAYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; STREET ADDRESS (If rural, give location) 119 S. ALLEGANY STREET

3. NAME OF DECEASED (Type or Print): (First) WALTER (Middle) (Last) BRANDLER

4. DATE OF DEATH: (Month) 9 (Day) 9 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE

8. DATE OF BIRTH: FEB. 18 1868

9. AGE last birthday: 82 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Coal Dealer

10b. KIND OF BUSINESS OR INDUSTRY: Selling Coal

11. BIRTHPLACE (State or foreign country): Cumberland Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: BRANDLER, J.N. M.

14. MOTHER'S MAIDEN NAME: MARY ISABELLE WILLISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL CUMBERLAND MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: From 8.20.50.

331X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8.20., 1950 to 9-9-, 1950, that I last saw the deceased alive on 9-9-, 1950 and that death occurred at 5:45 P m., from the causes and on the date stated above.

SIGNATURE W.F. Williams (Degree or title) ADDRESS M.D. Cumberland DATE SIGNED 9-10-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Sept 12/50 — NAME OF CEMETERY OR CREMATORY: Rose Hill Mausoleum — LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REG.: Sept. 11, 1950 — REGISTRAR'S SIGNATURE: Walter L. Manly, M.D.

24. FUNERAL DIRECTOR: William H. Kight — ADDRESS: Cumberland, Md.

15602

RECEIVED
SEP 19 1990
BUREAU

08802

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mc Coole (rural) LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.#3

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mc Coole (rural)
STREET ADDRESS (If rural give location) R.F.D #3

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Price (Last) Bean
4. DATE OF DEATH (Month) Sept. (Day) 21 (Year) 1950
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower
8. DATE OF BIRTH Sept.16-1860
9. AGE last birthday 90 yrs. If under 1 year Months - Days 5 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Owner - retired
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Ashland, Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Bean
14. MOTHER'S MAIDEN NAME Elizabeth Gobel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT J.T.Bean

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac failure	at once
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral hemorrhage (apoplexy)	3 yrs.
93d	Cardio-vascular disease	3 or 4 yrs
	(c) Arteriosclerosis	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Sept.25-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9-23-50
NAME OF CEMETERY OR CREMATORY Queens Point Cemetery
LOCATION (City, town, or county) Keyser, (State) W. Va.
DATE REC'D BY LOCAL REG. Sept 30/50
REGISTRAR'S SIGNATURE A. Gazenbaker M.D.
24. FUNERAL DIRECTOR Rogers Funeral Home, ADDRESS Keyser, W.Va.

000 VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 11 1950
BUREAU Y. S

Evidence for change of age shown on:

FILM NO. G 1 28 OCT 19 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08803

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; MARYLAND; LENGTH OF STAY (in this place) 14 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MT. Savage; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Charles	Thomas	Blucker	Sept.	25	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	12/30/1874	75 78 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Conductor for C&P R.R.	Railroad	MT. Savage MD.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Blucker	Ella

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	no	Isabell Blucker MT. Savage Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (a)	Cerebral Hemorrhage	2 weeks -
331X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 83a (b)	Vascular Hypertension	Several Years -
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Complete Paralysis Left side of body — 2 weeks -

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 9-11, 1950, to 9-25, 1950, that I last saw the deceased alive on 9-25, 1950, and that death occurred at 10:25 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
William E. Morley	M.D.	Mt Savage Md.	Sept. 27-1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/28/1950	MT. Savage Methodist	Mt. Savage Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-28-50	Mrs. Nancy A. Roe	Harvey H. Teigler	Hyndman, Pa.

10547

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 3 1989
BUREAU OF

Dr. McLane

08804

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): (BABY) BOND	4. DATE OF DEATH (Month) (Day) (Year): Sept. 4, 1950
5. SEX: Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): — 8. DATE OF BIRTH: Sept 3 1950	9. AGE last birthday: yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): — 10b. KIND OF BUSINESS OR INDUSTRY: —	11. BIRTHPLACE (State or foreign country): Frostburg, Md. — 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Arthur Bond	14. MOTHER'S MAIDEN NAME: Marian Hughes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): — 16. SOCIAL SECURITY NO.:	17. INFORMANT AND ADDRESS: Arthur Bond, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Prematurity 30 weeks

776x Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 3, 1950, to Sept 4, 1950, that I last saw the deceased alive on Sept 4, 1950, and that death occurred at 8 55 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm McLane MD		Frostburg Md	9-5-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 9-5-1950	NAME OF CEMETERY OR CREMATORY: Frostburg Mem'l Park	LOCATION (City, town, or county) (State): Frostburg, Md.
DATE REC'D BY LOCAL REG.: 9-5-50	REGISTRAR'S SIGNATURE: Mrs Nancy H Roe	24. FUNERAL DIRECTOR: J. R. Durst,	ADDRESS: Frostburg, Md.

2-0-9-03-0-32-1-30-2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
SEP 11 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

08805

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): Route 2

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ELMER	SOLOMON	CATON	Sept.	5,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	single	9-5-1940	10 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
student	school	Finzel, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Earl C. Caton	Nannie Albright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	none	Mrs. Earl Caton, Frostburg, Md. Rt. 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

812.5 **Immediate cause** (a) Depressed fracture Skull - rt. occipital region — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.

170 C **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hemorrhage

(c) Comp. Fracture Rt. Femur

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	Rt. 546	near Finzel	Garrett	Md

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☑	HOW DID INJURY OCCUR?
Sept 5-1950 7:15 P.M.		Struck by automobile

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. L. Baumgartner	M.D.	Oakland Md	9/5/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	9-8-50	Johnson Cemetery	Garrett County,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-7-50	Mrs. Nancy V. Roe	J. R. Durst, Frostburg, Md.	

RECEIVED
SEP 11 1950
BUREAU V. S

Within corporate limits

08806

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 708 Maryland Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 708 Maryland Avenue

3. NAME OF DECEASED (Type or Print): (First) MATTHEW (Middle) BERNARD (Last) COFFEY

4. DATE OF DEATH: (Month) SEPTEMBER (Day) 30, (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Aug. 4, 1875

9. AGE last birthday: 75 yrs. — If under 1 year: Months. If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Gen'l.Mgr. Johnson

10b. KIND OF BUSINESS OR INDUSTRY: Milling Co.

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Patrick Coffey

14. MOTHER'S MAIDEN NAME: Julia Malone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-18-1599

17. INFORMANT: Mrs. Rose Coffey, Cumberland, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
422.1 Immediate cause	(a) Chronic Myocarditis	7 years
Antecedent cause(s)		
932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	2½ years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 14, 1950, to Sept 30, 1950, that I last saw the deceased alive on Sept 28, 1950, and that death occurred at 3:45 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title): R. W. Trwaski, Jr — ADDRESS: Cumberland, Md. — DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 3, 1950	S.S.Peter & Paul Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.: Oct. 2, 1950

REGISTRAR'S SIGNATURE: Hunter K. Wantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: H. Wayne George, Cumberland, Maryland

156 XH

RECEIVED
OCT 9 1950
BUREAU V. S

Within corporate limits

DR. TOLSON -

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08807

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD.
LENGTH OF STAY (in this place): 26 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 135 N. CENTER ST.,

3. NAME OF DECEASED (Type or Print): (First) STELLA (Middle) E. Elizabeth (Last) COLLETT

4. DATE OF DEATH: (Month) SEPT. (Day) 29 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: SEPT. 25 1890

9. AGE last birthday: 60 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: ELI E. SMITH

14. MOTHER'S MAIDEN NAME: MARY M. STONAKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs Catherine Weese 135 N. Centre St Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): adeno-carcinoma - kidney

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): with liver metastases

(c)

INTERVAL BETWEEN ONSET AND DEATH

1804 520

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9-15-50

19b. MAJOR FINDINGS OF OPERATION: R. nephrectomy

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-3-, 1950, to 9-29-, 1950, that I last saw the deceased alive on 9-28-, 1950, and that death occurred at 9 45 am. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Howard L. Tolson, MD ADDRESS

DATE SIGNED: 9-30-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Oct 1 1950

NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem.

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 1, 1950

REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 9 1950
BUREAU V. S

Within corporate limits

Dr. Hodges

08808

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

C

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 305 South St

3. NAME OF DECEASED (Type or Print): (First) Judith (Middle) Ann (Last) Cooper

4. DATE OF DEATH: (Month) Sept (Day) 9 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept 9, 1950

9. AGE last birthday: yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours 10 / Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Vincent Cooper

14. MOTHER'S MAIDEN NAME: Harriett Pauline Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Vincent Cooper, 305 South St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a): Atelectasis - Plugged bronchi.

761.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Prematurity.

160e (c): Premature rupture of membranes

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 9, 1950, to Sept. 9, 1950, that I last saw the deceased alive on ....., 19....., and that death occurred at 2:45 P.m., from the causes and on the date stated above.

SIGNATURE: W. Royce Hodges (Degree or title) — ADDRESS: Cumberland, Md. — DATE SIGNED: 9/10/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 9/10/50 — NAME OF CEMETERY OR CREMATORY: Zion Memorial Park — LOCATION (City, town, or county): Cumberland, (State): Md.

DATE REC'D BY LOCAL REG.: Sept. 10, 1950 — REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR: John J. Hofer, Cumberland, Md. — ADDRESS:

2-0-9-09-0-33-1-36-2

RECEIVED
SEP 19 1950
BUREAU V. I

MARYLAND STATE DEPARTMENT OF HEALTH

08809

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; MARYLAND; LENGTH OF STAY (In this place): 1 day 33 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural give location): rear-134 Reynolds St

3. NAME OF DECEASED (Type or Print): (First) Oscar (Middle) T (Last) Cross

4. DATE OF DEATH: (Month) Sept. (Day) 13 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: March 27-1909

9. AGE last birthday: 41 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Sterla Motor Co.

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Rashore Cross

14. MOTHER'S MAIDEN NAME: Mary J. Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War II

16. SOCIAL SECURITY NO.: 214-05-6331

17. INFORMANT: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral edema (marked)	3.1/2 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Atelectasis bi.lateral (moderate)	
	(c) Pulmonary edema & congestion Post operative	

586.X
1271

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Sept.13-1950

19b. MAJOR FINDINGS OF OPERATION: Cholecystectomy&appendectomy (see cause of death)

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland, Md Sept.13-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Sept. 16, 1950 | NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park | LOCATION (City, town, or county) (State): Cumberland, Md

DATE REC'D BY LOCAL REG.: Sept. 15, 1950 | REGISTRAR'S SIGNATURE: Winter R. Beatty, M.D. | 24. FUNERAL DIRECTOR ADDRESS: John J. Hoffe Cumberland, Md.

42039

VS. A15A

RECEIVED
SEP 19 1950
BUREAU V. S.

Within corporate limits DR. MURRAY

08810

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 3 MONTHS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MT. SAVAGE
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) HENRIETTA (Middle) (Last) CROW
4. DATE OF DEATH (Month) SEPT. (Day) 21 (Year) 1950
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH MAY 6 '76
9. AGE last birthday 74 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Private nurse
10b. KIND OF BUSINESS OR INDUSTRY Nursing
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM CROW
14. MOTHER'S MAIDEN NAME ISABELLA, GRAHAM
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
176X	Immediate cause	(a) Carcinoma R groin following Exhaustion	5 months
49d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma R side Vulva	1 year ago
		(c) Emeral Carcinoma in pelvic organs	6 mos

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Sept 1949
19b. MAJOR FINDINGS OF OPERATION Carcinomatous growth R vulva Removed
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1949, to Sept 21, 1950, that I last saw the deceased alive on Sept 21, 1950, and that death occurred at 3:13 P.m., from the causes and on the date stated above.

SIGNATURE F. Alan G. Murray M.D. (Degree or title) ADDRESS Cumberland Md DATE SIGNED Sept 21 1950

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF 9-24-50
NAME OF CEMETERY OR CREMATORY EPISCOPAL CEMETERY
LOCATION (City, town, or county) (State) MT. SAVAGE, MD.
DATE REC'D BY LOCAL REG. Sept. 23, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR J. R. DURST, FROSTBURG, MD. ADDRESS

13692

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 26 1950
BUREAU V. S

DR. DURRETT

Within corporate limits

08811

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, LENGTH OF STAY (in this place) 6½ HOURS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 719 MEMORIAL AVENUE

3. NAME OF DECEASED (Type or Print) (First) EDGAR (Middle) H. (Last) DAVIS
4. DATE OF DEATH (Month) SEPT. (Day) 13. (Year) 1950
5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH OCT. 27, 1893
9. AGE last birthday 56 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED owner
10b. KIND OF BUSINESS OR INDUSTRY News + Tobacco Store
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MILLARD F. DAVIS
14. MOTHER'S MAIDEN NAME MARGARET FREDERICK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-14-1031
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL -CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
422.2 Immediate cause	(a) Uraemia	2 wks.
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocarditis c̄ Dilatation	3 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Nut While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948 to Sept. 13, 1950, that I last saw the deceased alive on Sept. 12, 1950, and that death occurred at 1 a. m., from the causes and on the date stated above.

SIGNATURE Clay E. Durrett (Degree or title) - ADDRESS Cumberland DATE SIGNED 9/13/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9/15/50
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Sept. 15, 1950
REGISTRAR'S SIGNATURE Winter K. Frantz M.D.
24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md. ADDRESS

15660

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 19 1950
BUREAU V. S

Within corporate limit.

08813

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 63 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 412 Goethe St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 412 Goethe St

3. NAME OF DECEASED (Type or Print) (First) Margaret (Middle) M (Last) Dawson
4. DATE OF DEATH (Month) Sept (Day) 23 (Year) 1950
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 14, 1886
9. AGE last birthday 64 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Deer Park, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John S. Nee
14. MOTHER'S MAIDEN NAME Mary Brockey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mr. T. A. Dawson 412 Goethe St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH 1 hr

Antecedent cause(s) (b) Hypertensive C.V. Disease — Unknown

443X 93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arteriosclerosis — Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from approx July 1948 to 9/23, 1950, that I last saw the deceased alive on 9/23, 1950, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

SIGNATURE Lewis T Rees MD (Degree or title) ADDRESS 404 Beechwood St DATE SIGNED 9/25/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Sept 26, 1950
NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.
LOCATION (City, town, or county) (State) Cumberland, Md

DATE REC'D BY LOCAL REG. Sept. 26, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer, Cumb, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 3 1950
BUREAU F.

Within corporate limits

Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

018812

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

I

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 15 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural near Cumberland
STREET ADDRESS (If rural, give location): Oldtown Road

3. NAME OF DECEASED (Type or Print): (First) Wm (Middle) Alexander (Last) Dolan

4. DATE OF DEATH: (Month) Sept (Day) 19 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 28, 1872

9. AGE last birthday: 78 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Supervisor (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: State Road Commission

11. BIRTHPLACE (State or foreign country): Flintstone Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Andrew Dolan

14. MOTHER'S MAIDEN NAME: Cassandra Hamilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs Lena Owens 528 Woodside Ave City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocarditis — Interval Between Onset and Death: 7 yrs.

422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

93 d (b) Arteriosclerosis — 10 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1, 19 50, to Sept. 19, 19 50, that I last saw the deceased alive on Sept. 19, 19 50, and that death occurred at 4 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Chas E. Lunn M.D. ADDRESS: Cumberland DATE SIGNED: 9/20/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Sept 21, 1950 — NAME OF CEMETERY OR CREMATORY: Oldtown Cemetery — LOCATION (City, town, or county): Oldtown — (State): Md.

DATE REC'D BY LOCAL REG.: Sept 21, 1950 — REGISTRAR'S SIGNATURE: Walter K. Mantz M.D.

24. FUNERAL DIRECTOR: John J Hafer - Cumberland Md. ADDRESS

15648

RECEIVED
SEP 26 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

08814

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 1 week
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 422 Columbia St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: N.Y; COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: New York City
STREET ADDRESS (If rural give location): 16 E. 53 rd St. ✓

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) Nicholas (Last) Duemmling
4. DATE OF DEATH: (Month) Sept. (Day) 26 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	White	single	June 24-1904	46 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Textile	Mass.	U.S.A.

13. FATHER'S NAME: John Duemmling
14. MOTHER'S MAIDEN NAME: Emlie Franke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: 265-07-5699
17. INFORMANT: Sister Ida Gens, 70 E. 96th St. New York N.Y.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary tuberculosis	7 mo.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

002X 135

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming, M.D.		Cumberland Md.	Sept.27-1950

23. BURIAL, CREMATION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Cremation	9/29/50	Fresh Pond Crematory	Maspeth, Queens, N.Y.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 27, 1950	Winter K. Mantz, M.D.	John J. Hafer, Cumberland, Md.	

22805

VS. A15A

Within corporate limits

08815

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 1.1/4 Hr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) near- Cumberland
STREET ADDRESS (If rural give location) Braddocks Farm, R. F. D. #5

3. NAME OF DECEASED (Type or Print) (First) Cora (Middle) Eliza (Last) Easton
4. DATE OF DEATH (Month) Sept. (Day) 2 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Jan.12-1879
9. AGE last birthday 71 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Piney Grove, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Josephus Norris
14. MOTHER'S MAIDEN NAME Mary Creek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT Charles Easton (son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
812.5 Immediate cause	(a) Shock, due to fractured left humerous, Compound comminuted fracture of lower left leg,	1.1/2 hrs
170c Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Fracture of right femur & right wrist.	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) route 40 near highway, LaVale Inn. (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) 9- 2-50-6.28Pm.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Walked out on highway and was hit by auto. going west.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Sept.2-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept. 6. 1950
NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Sept. 5, 1950
REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein, Inc. ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 15 1950
BUREAU V. S

08816

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Corriganville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Corriganville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Lee (Last) Emerick
4. DATE OF DEATH (Month) 9 (Day) 19 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 11/ 14/1934
9. AGE last birthday 15 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Corriganville
12. CITIZEN OF WHAT COUNTRY? Usa

13. FATHER'S NAME Melvin Emerick
14. MOTHER'S MAIDEN NAME Ruth Ford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. no
17. INFORMANT AND ADDRESS Melvin Emerick Corriganville Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

421.4 Immediate cause (a) Chronic Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 8 yrs.

92b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1940, to Sep 19, 1950, that I last saw the deceased alive on Sep 19, 1950, and that death occurred at 4:30 A m., from the causes and on the date stated above.

SIGNATURE John A Topper (Degree or title) ADDRESS Hyndman Pa DATE SIGNED 9/20/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9/ 21/1950
NAME OF CEMETERY OR CREMATORY Ford Cemetery
LOCATION (City, town, or county) Corriganville, (State) Md.

DATE REC'D BY LOCAL REG. Sept 20 1950
REGISTRAR'S SIGNATURE J. Lloyd Wolfe
24. FUNERAL DIRECTOR Harvey H. Zeigler ADDRESS Hyndman, Pa.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

RECEIVED
OCT 13 1950
BUREAU V. P

Within corporate limits DR. DYER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08817

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

I

VS. A15

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (In this place) 7 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 113 BELLEVUE STREET

3. NAME OF DECEASED (Type or Print) (First) MARGARET (Middle) (Last) ENGLE

4. DATE OF DEATH (Month) SEPT. (Day) 28 (Year) 1950

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED

8. DATE OF BIRTH AUG. 3, 188[illegible]

9. AGE last birthday 69[illegible] yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME SCOTT DIEHL

14. MOTHER'S MAIDEN NAME MARY RIZER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL -CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardiac failure	1 week
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	10 yrs.
	(c) Diabetes mellitus	20 yrs

260 X 61

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug., 1950, to 9-28, 1950, that I last saw the deceased alive on 9-27, 1950, and that death occurred at 4:10 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Thos A. Dyer M.D. 242 Va Ave 9-29-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Sept 30, 1950

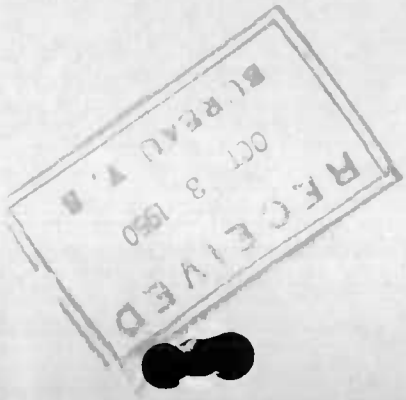
NAME OF CEMETERY OR CREMATORY St Peters and Pauls

LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. Sept. 29, 1950

REGISTRAR'S SIGNATURE Walter L. Rantz, M.D.

24. FUNERAL DIRECTOR. ADDRESS Louis Stein, Inc., Cumberland Md


RECEIVED
OCT 3 1950
BUREAU T. B

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

08818

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 207 Potomac St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Ohio — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Akron (rural)
STREET ADDRESS (If rural give location): R.F.D.#8 Box 1223 ✓

3. NAME OF DECEASED (Type or Print): (First) Barbara (Middle) Jersey (Last) Erhard
4. DATE OF DEATH: (Month) Sept (Day) 28 (Year) 1950
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: April 27-1880
9. AGE last birthday: 70 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Owens
14. MOTHER'S MAIDEN NAME: Betty Kirchner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Edna Guthrie, Akron, Ohio

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute cardiac failure due to — at once

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic myocarditis — several years

260 X 61

(c) Diabetes — about 10 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. V. Deming M.D. H. V. Deming M.D. Cumberland, Md. Sept. 28-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Oct. 2, 1950 | NAME OF CEMETERY OR CREMATORY: Talmadge Cemetery | LOCATION (City, town, or county) (State): Near Akron, Ohio

DATE REC'D BY LOCAL REG.: Sept. 29, 1950 | REGISTRAR'S SIGNATURE: Winter K. Rantz, M.D. | 24. FUNERAL DIRECTOR ADDRESS: James E. Scarpelli, Cumberland, Md.

RECEIVED
OCT 3 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

08819

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (In this place) 16 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS 211 (If rural give location) Welsh Hill

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Henry (Last) Evans
4. DATE OF DEATH (Month) Sept (Day) 29 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan. 21-1880
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant
10b. KIND OF BUSINESS OR INDUSTRY Grocery
11. BIRTHPLACE (State or foreign country) Osterburg Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Samuel Evans
14. MOTHER'S MAIDEN NAME Barbara
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. -----
17. INFORMANT Clarence Evans

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
901.0	Immediate cause	(a) Acute cardiac failure due to	
186a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Shock from a 8 ft fall	16 hrs.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒* CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
(CITY OR TOWN) Frostburg (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Sept. 28/50-3P m.
INJURY OCCURRED While at work ☒ Not while at work ☐
HOW DID INJURY OCCUR? Taring roof, bottom of ladder kicked out & fell to concrete pavement

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒*, Inquiry ☐* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒*, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H. V. Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Sept. 30-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10-2-1950
NAME OF CEMETERY OR CREMATORY Frostburg Mem Cem.
LOCATION (City, town, or county) Frostburg (State) Md.
DATE REC'D BY LOCAL REG. 10-2-50
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

15661

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

M

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T

RECEIVED
OCT 9 1960
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08820

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 105 Valley St.,

3. NAME OF DECEASED (Type or Print): (First) Nell (Middle) Pferdeort (Last) Flick

4. DATE OF DEATH: (Month) Sept. (Day) 3, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Mar. 17, 1889

9. AGE last birthday: 61 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Pittsburg, Penna.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Charles Pferdeort

14. MOTHER'S MAIDEN NAME: Margaret Hoffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. E. Earl Darber Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X 83a

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: Acute

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) High Blood Pressure — 2 Year

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While ~~at~~ ~~Not While~~ Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/5 48, to Sept 50., that I last saw the deceased alive on 9/3 1950, and that death occurred at 2:35 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John K Rowland MD Cumberland Md 9/5/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Sept. 6, 1950 — NAME OF CEMETERY OR CREMATORY: St. Lukes Cem. — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG. Sept. 6, 1950 — REGISTRAR'S SIGNATURE: Walter L. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: H. Wayne George Cumb. Md.

52086

RECEIVED
SEP 15 1950
BUREAU V. S.

Skitarelick

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08821

CERTIFICATE OF DEATH

Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN: rural Flintstone
MARYLAND
LENGTH OF STAY (in this place): 60 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Town Creek Road.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural Flintstone
STREET ADDRESS (If rural, give location): Town Creek Road.

3. NAME OF DECEASED (Type or Print): (First) Amanda (Middle) (Last) Frazee

4. DATE OF DEATH: (Month) Sept (Day) 15 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Dec. 12, 1863

9. AGE last birthday: 86 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Murley's Branch, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Chaney

14. MOTHER'S MAIDEN NAME: Henrietta Roberts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Leslie L. Lammert, Woodbury, N.J.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	10 days.
331X 83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	10 yrs
	(c) Arteriosclerosis	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 6, 1950, to Sept 15, 1950, that I last saw the deceased alive on Sept 12, 1950, and that death occurred at 6 00 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Benedict Skitarelic M.D. Rt #2 Cumberland Md.

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Sept 18, 1950

NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Sept. 18, 1950

REGISTRAR'S SIGNATURE: Nina L. Bender

24. FUNERAL DIRECTOR: John J. Hafer, Cumberland, Md.

ADDRESS

RECEIVED
SEP 20 1930
BUREAU N. S

Dr. W. A. Van Ormer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08822

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Pennsylvania COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bedford
STREET ADDRESS (If rural, give location) 509 East Penn Street ✓

3. NAME OF DECEASED (Type or Print): (First) Marjorie (Middle) A. (Last) Gochnour
4. DATE OF DEATH (Month) (Day) (Year): September 4. 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: June 15, 1897
9. AGE last birthday: 53 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Imler, Joseph P.
14. MOTHER'S MAIDEN NAME: Weyandt, Susan C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Memorial Hospital. Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis with Infarction (Pulmonary)	10 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arteriosclerosis	
260 X 61	(c) Diabetes Mellitus	20 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Obesity

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 28 Aug, 1950, to 4 Sept, 1950, that I last saw the deceased alive on 4 Sept 50, 19..., and that death occurred at 1.25 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. Alfred Van Ormer
ADDRESS: Cumberland, Md.
DATE SIGNED: 5 Sept 50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Sept. 7, 1950
NAME OF CEMETERY OR CREMATORY: Bedford Co. Memorial
LOCATION (City, town, or county) (State): Bedford, Penna.

DATE REC'D BY LOCAL REG.: Sept. 6, 1950
REGISTRAR'S SIGNATURE: Winter R. Kantz M.D.
24. FUNERAL DIRECTOR: H. Wayne George
ADDRESS: Cumberland, Md.

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 15 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr W. Lane

08823

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 16 Hill St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 16 Hill St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MICHAEL	FRANCIS	GRIMES	Sept.	7,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	married	6-16-1879	71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machine helper	Celanese plant	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Grimes	Bridget Dugan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	217-10-5224-A	Francis Grimes, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 2 yrs

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Sept 1, 1950, to Sept 7, 1950, that I last saw the deceased alive on Sept 1, 1950, and that death occurred at 4:00 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm Lane	MD	Frostburg Md	9-8-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-9-1950	St. Michael's Cemetery	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-9-50	Mrs Nancy N. Roe	J. R. Durst, Frostburg, Md.	

4616

RECEIVED
SEP 14 1950
BUREAU OF S

Within corporate limits

08824

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Co. Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 426 Columbia St.

3. NAME OF DECEASED (Type or Print) (First) Frederick (Middle) Howard (Last) Grimm

4. DATE OF DEATH (Month) Sept. (Day) 9 (Year) 1950

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH May 30, 1875
9. AGE last birthday 75 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector
10b. KIND OF BUSINESS OR INDUSTRY W. M. R. R.
11. BIRTHPLACE (State or foreign country) Winchester, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Grimm
14. MOTHER'S MAIDEN NAME Mary Blessing

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 217-10-1933
17. INFORMANT AND ADDRESS Leo H. Grimm, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial Failure	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	5 yrs
	(c)	

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1946, to Sept. 9, 1950, that I last saw the deceased alive on Sept. 7, 1950, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

SIGNATURE Arthur F. Jones (Degree or title) M.D. ADDRESS 110 S. Centre St. DATE SIGNED Sept. 11, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept 11, 1950
NAME OF CEMETERY OR CREMATORY Sts. Peter & Pauls Cemetery
LOCATION (City, town, or county) Cumberland, (State) Md.

DATE REC'D BY LOCAL REG. Sept. 11, 1950
REGISTRAR'S SIGNATURE Hunter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md. ADDRESS

31847

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 19 1950
BUREAU W. S

08825

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (In this place): 70yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 76 Bowery St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural give location): 76 Bowery St.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (Last) Gunnett
4. DATE OF DEATH: (Month) Sept (Day) 1 (Year) 19 50

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: Sept.12-1879
9. AGE last birthday: 70 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Frostburg,Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Conrod Brode
14. MOTHER'S MAIDEN NAME: Martha Warner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: ------
17. INFORMANT: George Gunnett

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac Failure due to	at once
422.2 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocarditis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland,Md. Sept.1-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 9-3-50
NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park
LOCATION (City, town, or county) (State): Frostburg,Md.

DATE REC'D BY LOCAL REG. 9-1-50
REGISTRAR'S SIGNATURE: Mrs Nancy N. Roe
24. FUNERAL DIRECTOR ADDRESS: Jacob Hafer, 23 E. Main St. Frostburg Md.

RECEIVED
SEP 5 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08826

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 3 Months; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland,; STREET ADDRESS (If rural, give location) Route 4, Williams Road

3. NAME OF DECEASED (Type or Print): (First) Rebecca (Middle) (Last) Hamilton

4. DATE OF DEATH: (Month) Sept (Day) 8 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: July 1 1876

9. AGE last birthday: 74 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House ~~Wife~~ Home Wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Cumberland, Md

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Hanson Bucy

14. MOTHER'S MAIDEN NAME: Mary Ann Dunn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Woodrow Hamilton Route # 4.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cirrhus Carcinoma Vulva — Interval Between Onset and Death: 2½ yrs

176 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 49d

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 26, 1950, to Sept 8, 1950, that I last saw the deceased alive on Sept. 7, 1950, and that death occurred at 8 55 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur F. Jones M. D. 110 S. Centre St. Sept. 11, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Sept 12 1950 — NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery — LOCATION (City, town, or county): Cumberland — (State): Md.

DATE REC'D BY LOCAL REG.: Sept. 11, 1950 — REGISTRAR'S SIGNATURE: Hunter R. Tanty, M.D

24. FUNERAL DIRECTOR: William H. Kight, — ADDRESS: Cumberland, Md.

RECEIVED
SEP 19 1930
BUREAU V. S

Within corporate limits

Dr. W.F. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08827

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg, Maryland
STREET ADDRESS (If rural, give location): 52 Bowery Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jane	Muir	Haney	9/19/50 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Mln.
Female	White	Married	May 26 1907	43 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk, Benjamin Evans - Boiler Dept.
10b. KIND OF BUSINESS OR INDUSTRY: Lonaconing Mf'g
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Muir, Frank
14. MOTHER'S MAIDEN NAME: Jones, Nellie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 214-10-3804
17. INFORMANT AND ADDRESS: Memorial Hospital, Cumberland, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Aplastic Anemia	?
292.4 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
782	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 8-29, 1950, to 9/19, 1950, that I last saw the deceased alive on 9-19, 1950, and that death occurred at 10:23 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Dr. F. Bikimas MD Cumberland 9-19-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 22, 1950	Laurel Hill Cemetery	Moscow, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 20, 1950	Wilmer L. Frantz, M.D.	M. Eichhorn	Lonaconing, Maryland

VS. A15

26684

RECEIVED
SEP 26 1950
BUREAU V. S

DR. ~~ROBINSON~~ Mirkin

08828

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 88 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SHALLMAR
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) WALTER	(Middle) CECIL	(Last) HEDRICK	4. DATE OF DEATH	(Month) SEPT.	(Day) 14.	(Year) 1950
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH FEB. 21. 1949	9. AGE last birthday 1 yr.	If under 1 year Months 6	Days 23	If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA.				
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME MINNIE MAULE						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Mrs. Minnie Maule Hedrick (Mother) ~~MEMORIAL HOSPITAL CUMBERLAND, MD.~~					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
180X Immediate cause	(a) Sarcoma Rt Kidney (Wilms)	6-8 mo.
52a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 6-22-50	19b. MAJOR FINDINGS OF OPERATION Wilms tumor of Rt Kidney.	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-18, 1950, to 9-14, 1950, that I last saw the deceased alive on Sept 13, 1950 and that death occurred at 1.00 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

A J Mirkin M.D. 115 So. Centre Cumberland

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Sept 16-1950	NAME OF CEMETERY OR CREMATORY Oakland	LOCATION (City, town, or county) (State) Oakland Md
DATE REC'D BY LOCAL REG. Sept. 15, 1950	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR Emray Boldin,	ADDRESS Oakland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

2802.

RECEIVED
SEP 19 1960
BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08829

Dr. P. R. Wilson

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: "esternport; MARYLAND; LENGTH OF STAY (In this place): 80 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 108 Cromer St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport; STREET ADDRESS (If rural, give location): 108 Cromer Street

3. NAME OF DECEASED (Type or Print): (First) LEWIS (Middle) JACOB (Last) HEILAND

4. DATE OF DEATH: (Month) Sept (Day) 4, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov 25 1869

9. AGE last birthday: 80 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): Westernport, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lewis Joshua Heiland

14. MOTHER'S MAIDEN NAME: Marie Berg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - -

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Frederick Zachgo (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Edema	1 Day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis and Myocardial Degeneration Not Specified as rheumatic	5 Years
	(c)	

422.2
932

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 30, 1950, to Sept. 4, 1950, that I last saw the deceased alive on Sept. 4, 1950, and that death occurred at 7:40 P m., from the causes and on the date stated above.

SIGNATURE: Paul R Wilson (Degree or title): MD ADDRESS: Piedmont, W.Va DATE SIGNED: Sept. 5, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: Sept 7, 1950; NAME OF CEMETERY OR CREMATORY: Philos Cemetery; LOCATION (City, town, or county) (State): Westernport, Maryland

DATE REC'D BY LOCAL REG.: Sept. 7/50; REGISTRAR'S SIGNATURE: [illegible] M.D.

24. FUNERAL DIRECTOR: E.S. Boal, "esternport, Maryland ADDRESS

30809

RECEIVED
SEP 15 1960
BUREAU

08830

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt Savage — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Main St.	STREET ADDRESS (If rural, give location): Main St.

3. NAME OF DECEASED (Type or Print)	(First) Leo	(Middle) Jordan	(Last) Henaghan	4. DATE OF DEATH	(Month) Sept. (Day) 11 (Year) 1950
5. SEX: Male	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 12-20-1906	9. AGE last birthday: 43 yrs.	If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY: Confectionery	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: John Henaghan	14. MOTHER'S MAIDEN NAME: Annie Wilderman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):	16. SOCIAL SECURITY No.: none	17. INFORMANT AND ADDRESS: Bernard Henaghan, Eckhart Md.			

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause	(a) CORONARY THROMBOSIS ANGINA PECTORIS	6 MONTHS
17b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) MODERATE VASCULAR HYPERTENSION	1 YEAR
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	TUBERCULAR HIP JOINT, CHRONIC.	SEVERAL YEARS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JANUARY 1949, to 9-12, 1950, that I last saw the deceased alive on 9-12, 1950, and that death occurred at 2:20 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
William E. Moseley		Mt Savage Md.	Sept. 12. 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 9-13-50	NAME OF CEMETERY OR CREMATORY: St. Michaels	LOCATION (City, town, or county) (State): Frostburg
DATE REC'D BY LOCAL REG.: 9-12-1950	REGISTRAR'S SIGNATURE: Veronica McDermott	24. FUNERAL DIRECTOR: J. R. Dunn	ADDRESS: Frostburg Md

XVX60

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

RECEIVED
SEP 15 1950
BUREAU V. S

Within corporate limits

08831

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland, LENGTH OF STAY (in this place): 1 day	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: La Vale
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural, give location): 602 National Pike

3. NAME OF DECEASED (Type or Print)	(First) BETTY	(Middle) JANE	(Last) HESS	4. DATE OF DEATH	(Month) Sept. (Day) 1, (Year) 1950
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH: Mar. 29, 1934	9. AGE last birthday: 16 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student	10b. KIND OF BUSINESS OR INDUSTRY: High School	11. BIRTHPLACE (State or foreign country): Galeton, Penna.	12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME: Edgar W. Hess		14. MOTHER'S MAIDEN NAME: Hulda Ingraham			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: Edgar Hess R. D. #1 La Vale, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute anterior poliomyelitis	5 days
Antecedent cause(s)	ascending type since	first symptom
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	1 day
	(c)	paralysis

080.3
36

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Congenital malformation of the heart

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 8/30, 1950, to 9/1, 1950, that I last saw the deceased alive on 9/1, 1950, and that death occurred at 11 50 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Elizabeth Briggs, M.D.		55 Greene St.	9/2/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Sept. 3, 1950	NAME OF CEMETERY OR CREMATORY: Hillcrest Cem.	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: Sept. 2, 1950	REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR: Charles L. George	ADDRESS: Cumb. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A14

RECEIVED
SEP 8 1950
BUREAU

M

08832

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (In this place) 9 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Savage
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Frederick (Middle) Joseph (Last) Hogamier

4. DATE OF DEATH (Month) September (Day) 8 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH 9/7/50
9. AGE last birthday yrs. If under 1 year Months. Days If under 24 hrs. Hours 9 Min. 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Frostburg Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frederick Allen Hogamier
14. MOTHER'S MAIDEN NAME Evelyn Loretta Lynch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Mother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.0 Immediate cause (a) Atelectasis

161a Antecedent cause(s) (b) Postmaturity -

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH 9 hrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) no
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/7, 1950, to 9/8, 1950, that I last saw the deceased alive on 9/8, 1950, and that death occurred at 6:00 AM m., from the causes and on the date stated above.

SIGNATURE Hilda Jane Walter M.D. (Degree or title) EST ADDRESS 48 Broadway Frostburg Md DATE SIGNED 9/8/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 9-8-1950
NAME OF CEMETERY OR CREMATORY St. Patricks Cem.
LOCATION (City, town, or county) (State) Mt. Savage, Md.

DATE REC'D BY LOCAL REG. 9-8-50
REGISTRAR'S SIGNATURE Mrs Nancy H. Roe
24. FUNERAL DIRECTOR J. R. Durst, Frostburg, Md, ADDRESS

2-0-9-07-0-35-1-43-7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 14 1950
BUREAU V. S

Dr. VAN ORMER

MARYLAND STATE DEPARTMENT OF HEALTH

08833

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; LENGTH OF STAY (in this place) 130 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland PENNSYLVANIA; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.; STREET ADDRESS (If rural, give location) 215 Elder St.

3. NAME OF DECEASED (Type or Print): (First) CORDELIA (Middle) SUE (Last) HORCHLER

4. DATE OF DEATH: (Month) SEPT. (Day) 19 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: NOVE 13 1881

9. AGE last birthday: 68 yrs. If under 1 year: Months; If under 24 hrs.: Days; Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE W. BARNES

14. MOTHER'S MAIDEN NAME: SARA JANE DIEHL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO. (If yes, give war or dates of service): None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebro - vascular accident	60 days
260X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arterio-sclerosis	?
61	(c) Diabetes mellitus	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 25 any 50, 19..., to 19 Sept., 19 50, that I last saw the deceased alive on SEPT? 19 19.50, and that death occurred at 9:00 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

W. Alfred V n Ormer — Cumberland - md. — 20 Sept 50 Md.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 9/22/50 — NAME OF CEMETERY OR CREMATORY: Fairview Cem. — LOCATION (City, town, or county) (State): Fairview, Pa

DATE REC'D BY LOCAL REG.: Sept. 21, 1950 — REGISTRAR'S SIGNATURE: Walter R. Dantz, M.D. — 24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cum

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 26 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08834

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 30 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 223 Race Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 223 Race Street

3. NAME OF DECEASED (Type or Print): (First) Jasper (Middle) Loring (Last) Huff
4. DATE OF DEATH: (Month) Sept (Day) 23 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married	May 18 1877	73 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Blacksmith
10b. KIND OF BUSINESS OR INDUSTRY: Shoeing Horses
11. BIRTHPLACE (State or foreign country): Town Creek, Maryland
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: William Huff
14. MOTHER'S MAIDEN NAME: Margaret Crabtree

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: H.L.Huff Rt 1, Mt Savage Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiac decompensation	2 days
420.1 / 95c Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary thrombosis	24 hrs.
	(c) Arteriosclerosis	10 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-22, 1950, to 9-22, 1950; that I last saw the deceased alive on 9-22, 1950, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
John A. Dyer, M.D. | 247 Virginia Ave | 9-23-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Sept 25 1950 | NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG. Sept. 25, 1950 | REGISTRAR'S SIGNATURE Walter L. Mantz, M.D.

24. FUNERAL DIRECTOR | ADDRESS: William H. Kight | Cumberland, Md.

30885

RECEIVED
OCT 3 1980
BUREAU F. S

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08835

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
MARYLAND
LENGTH OF STAY (in this place) 75 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 112 Park Heights

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural, give location) 112 Park Heights

3. NAME OF DECEASED (Type or Print) (First) Mildred (Middle) E. (Last) Jett

4. DATE OF DEATH (Month) Sept (Day) 25 (Year) 1950

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Write) Married | 8. DATE OF BIRTH Nov. 27 1886 | 9. AGE last birthday 63 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Cumberland Md | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph L. Sell | 14. MOTHER'S MAIDEN NAME Mary A Hammersmith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT AND ADDRESS Claude T Jett, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pneumonia	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 443X 131a	(b) Chronic Nephritis	4 or 5 yrs
	(c) Chronic Hypertension Heart disease	6 or 7 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1947, to Sept 25, 1950, that I last saw the deceased alive on Sept 24, 1950, and that death occurred at 8 30P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

F. Alan G. Mann MD Cumberland Md 9/26/50

23. BURIAL, CREMATION OR REMOVAL (Specify) Burial | DATE THEREOF Sept 28 50 | NAME OF CEMETERY OR CREMATORY Hillcrest Cem | LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Sept. 28, 1950 | REGISTRAR'S SIGNATURE Winter K. Dantz, M.D. | 24. FUNERAL DIRECTOR Lonie Stein Inc | ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 3 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

08836

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
MARYLAND — LENGTH OF STAY (in this place): 10 minutes
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Grantsville
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Guy	Hubert	Johnson	Sept	1	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	white	Single	Dec. 9-1902	47 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner & laborer	loading & diging coal	Grantsville Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Baker Johnson	Rebecca Bettinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	216-03-3550	Mrs. J.L.Miller (sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
924.5 Immediate cause	(a) Exsanguination due to torn femoral (right)	20 min.
170 C Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Artery, also fractured pelvis & left femur, compound comminuted fracture, right tibia & fibulae, large laceration left lower leg, large	
	(c) laceration of (torn) left thigh, anterior aspect, extending through rectum & left buttock.	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	highway route 40	Frostburg	Allegany	Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☒ Not while at work ☐	HOW DID INJURY OCCUR?
Sept. 1/50 2:50 p. m.		Brakes failed on truck, deceased jumped & fell under rear dual wheels.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D H. V. Deming M. D.	Cumberland, Md.	Sept 1-1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-4-1950	Grantsville	Grantsville Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-3-50	Mrs. Nancy N. Roe	Wm Winterberg	Grantsville Md

45402

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 5 1950
BUREAU V. S

Within corporate limits

08837

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 123 So. Smallwood St.

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) Agnes (Last) Kady

4. DATE OF DEATH: (Month) Sept. (Day) 18, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 3-6-1874

9. AGE last birthday: 76 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Fairmont, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John S. Hershberger

14. MOTHER'S MAIDEN NAME: Mary Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Otho Wymer Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Mesenteric Thrombosis	4 days.
570.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Intestinal obstruction	3 weeks
99	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949 to Sept. 18, 1950, that I last saw the deceased alive on Sept 16, 1950, and that death occurred at 1:30 P m., from the causes and on the date stated above.

SIGNATURE: B. M. Schindler (Degree or title) M.D. ADDRESS: 41 Greene St Cumberland Md DATE SIGNED: Sept 21 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 9-21-1950
NAME OF CEMETERY OR CREMATORY: Philos Cem.
LOCATION (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG.: Sept. 20, 1950
REGISTRAR'S SIGNATURE: Walter K. Kantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George
ADDRESS: Cumberland, Md.

RECEIVED
SEP 26 1950
BUREAU

Within corporate limits

08838

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 7 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 212 Spring St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 212 Spring St.

3. NAME OF DECEASED (Type or Print): (First) Barbara (Middle) (Last) Keller

4. DATE OF DEATH: (Month) Sept. (Day) 14 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: April 1-1866

9. AGE last birthday: 84 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? Germany

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Un Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Paul Keller, 212 Spring St, Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	?
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H. V. Deming M.D. H. V. Deming M.D.	Cumberland, Md.	Sept. 14-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept 16 1950	Trinity Lutheran Cem	Cumberland, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 16, 1950	Winter R. Hartz, M.D.	John J. Hofer	Cumberland, Md.

RECEIVED
SEP 19 1950
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

08839

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: rear-65 E.Main St

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural give location): rear-65 E.Main St.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Muir (Last) Kerr

4. DATE OF DEATH: (Month) Sept (Day) 8 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: July 6-1877

9. AGE last birthday: 73 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Glass carrier

10b. KIND OF BUSINESS OR INDUSTRY: Glass Factory

11. BIRTHPLACE (State or foreign country): Lonaconing Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Kerr

14. MOTHER'S MAIDEN NAME: Jane Muir

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 220-03-7830

17. INFORMANT: Thomas Kerr

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
Immediate cause	(a)	Acute cardiac failure due to	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	chronic myocarditis	?
	(c)		

4/22.2
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland, Md. Sept.11-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 9-12-1950
NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Cem.
LOCATION (City, town, or county) (State): Frostburg Md.

DATE REC'D BY LOCAL REG. 9-12-50
REGISTRAR'S SIGNATURE: Mrs Nancy H. Rose
24. FUNERAL DIRECTOR: Jacob Hafer
ADDRESS: Frostburg, Md.

49660

RECEIVED
SEP 15 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

118840

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (In this place) 6 Months; HOSPITAL OR INSTITUTION OR STREET ADDRESS 12 Centennial St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 12 Centennial St

3. NAME OF DECEASED (Type or Print): (First) George (Middle) [illegible] (Last) Koresion

4. DATE OF DEATH: (Month) Sept. (Day) 14 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1-3-1867

9. AGE last birthday: 83 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Borden Mines, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Koresion

14. MOTHER'S MAIDEN NAME: Rachel Gregatry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs Robt Hall Frostburg, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardio-vascular renal disease	2 years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteria-sclerosis	
	(c) Senility	

4427
131a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cystic goitre

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify); PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.); (CITY OR TOWN); (COUNTY); (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.; INJURY OCCURRED While at Work ☐ Not While At work ☐; HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-10, 1950, to 9-14, 1950, that I last saw the deceased alive on 9-14, 1950, and that death occurred at 12:50 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED: H. C. Dielil, M.D. Frostburg, Md. 9/15/50.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: 9-17-1950; NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Park; LOCATION (City, town, or county) (State): Frostburg Md

DATE REC'D BY LOCAL REG. 9-15-50; REGISTRAR'S SIGNATURE: Mrs. Nancy A. Roe

24. FUNERAL DIRECTOR ADDRESS: Jacob Hafer Frostburg, Md

30879

RECEIVED
SEP 21 1950
BUREAU V. S

Outside City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

08841

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LaVale
LENGTH OF STAY (in this place) 57 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Vale
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) (Last) Krapf
4. DATE OF DEATH (Month) Sept (Day) 8 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower
8. DATE OF BIRTH Dec-23-1862
9. AGE last birthday 87 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Mgr. of restaurant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Krapf
14. MOTHER'S MAIDEN NAME Anna Marie Schaub
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Ray Huster

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	?
	(c)	

420.1

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Sept.8-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept 10, 1950
NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
LOCATION (City, town, or county) Cumberland (State) Maryland
DATE REC'D BY LOCAL REG. Sept. 10, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein, Inc ADDRESS Cumberland, Md.

15671

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

RECEIVED
SEP 19 1950
BUREAU V. S

M

08842

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4 Beall St	STREET ADDRESS (If rural, give location): 4 Beall St.

3. NAME OF DECEASED (Type or Print)	(First) Madeline	(Middle) Bissett	(Last) Lee	4. DATE OF DEATH	(Month) Sept (Day) 11 (Year) 1950
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Jan 1902	9. AGE last birthday: 48 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trained Nurse	10b. KIND OF BUSINESS OR INDUSTRY: Hospital	11. BIRTHPLACE (State or foreign country): Piedmont, W.Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Keyran Bissett	14. MOTHER'S MAIDEN NAME: Agnes Spicer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS: Robert W. Lee Frostburg, Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
433.1	Immediate cause	(a) Chr Myocarditis	2 yrs
	Antecedent cause(s)		
932	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Auricular Fehrillation	"
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950, to Sept 11, 1950, that I last saw the deceased alive on Sept 11, 1950, and that death occurred at 7:00 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W O McLane	MD	Frostburg Md	9-12-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Sept. 14, 1950	NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery	LOCATION (City, town, or county) (State): Westernport Md.
DATE REC'D BY LOCAL REG.: 9-12-50	REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe	24. FUNERAL DIRECTOR: W. Harold Fredlock	ADDRESS: Piedmont, W.Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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V3692

RECEIVED
SEP 15 1950
BUREAU V. S.

Within corporate limits.

DR.W.F.WMS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08843

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND,
LENGTH OF STAY (in this place): 16 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near CUMBERLAND Rural
STREET ADDRESS (If rural, give location): RT # 2 BALTIMORE PIKE

3. NAME OF DECEASED (Type or Print): (First) ANNA (Middle) (Last) LITZENBURG

4. DATE OF DEATH: (Month) SEPT. (Day) 3 (Year) 19 5

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: AUGUST 4 1876

9. AGE last birthday: 74 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HUNTER GUMM

14. MOTHER'S MAIDEN NAME: ELIZABETH WILLISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY No.: NONE

17. INFORMANT AND ADDRESS: Stanton Litzenburg Cumbd Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardio Vascular Renal Disease (Uremia)

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Diabetes Mellitus 260X 61

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 14, 19 50, to Sept 3 19 50, that I last saw the deceased alive on 9-3-, 19 50, and that death occurred at 8:50 P. M. from the causes and on the date stated above.

SIGNATURE: W. F. Williams (Degree or title) MD ADDRESS: Cumberland DATE SIGNED: 9-3-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Sept 7 50

NAME OF CEMETERY OR CREMATORY: Pleasant View Cem.

LOCATION (City, town, or county) (State): East Cumberland Md.

DATE REC'D BY LOCAL REG.: Sept. 5, 1950

REGISTRAR'S SIGNATURE: Walter L. Beatty, M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc ADDRESS: Cumberland Md

RECEIVED
SEP 15 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr W C Lane

08844

Reg. Dist. No. 9

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 86 Spring St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 86 Spring St.

3. NAME OF DECEASED (Type or Print): (First) MARGARET (Middle) McKINNON (Last) LLOYD

4. DATE OF DEATH (Month) Sept. (Day) 6, (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 3-27-1886

9. AGE last birthday: 64 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas McKinnon

14. MOTHER'S MAIDEN NAME: Marian Mackey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Thomas Lloyd, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval between onset and death: 1 week

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4201 94a

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 2, 1950, to Sept 6, 1950, that I last saw the deceased alive on Sept 6, 1950, and that death occurred at 4:45 P m., from the causes and on the date stated above.

SIGNATURE: W C Lane MD (Degree or title) ADDRESS: Frostburg Md DATE SIGNED: 9-8-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 9-9-1950
NAME OF CEMETERY OR CREMATORY: Frostburg Mem'l Park
LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 9-9-50
REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md. ADDRESS

RECEIVED
SEP 14 1950
BUREAU V. S

M

08845

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) THOMAS (Middle) A. (Last) LOGSDON			4. DATE OF DEATH (Month) Sept. (Day) 7, (Year) 1950		
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH: 9-27-1869	9. AGE last birthday: 80 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired laborer	10b. KIND OF BUSINESS OR INDUSTRY: Brickyard		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Peter Logsdon			14. MOTHER'S MAIDEN NAME: Ellen Brennan		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.: none		17. INFORMANT AND ADDRESS: Geo. Carney, Cumberland, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Sterility & Suppression of Urine	sixty days
450.0 Antecedent cause(s)	(b) Arterio Sclerosis	several years
92 e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Myocarditis Chr., Endocarditis — several years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1940, to Sept 7, 1950, that I last saw the deceased alive on Sept 5, 1950, and that death occurred at 2:20 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Alan G. Murray	Md	Cumberland	Md

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 9-11-1950	NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery	LOCATION (City, town, or county) (State): Mt. Savage, Md.
DATE REC'D BY LOCAL REG.: 9-10-1950	REGISTRAR'S SIGNATURE: Vernon M. Dermett	24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md.	ADDRESS

988 73

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 14 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08846

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 15 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: W.VA. — COUNTY: Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ROMNEY
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Robert Paul (Middle) Maphis (Last)

4. DATE OF DEATH: (Month) SEPT. (Day) 15 (Year) 19 50

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: Aug 31 1950

9. AGE last birthday: yrs. — If under 1 year: Months — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): East Romney West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PAUL MAPHIS

14. MOTHER'S MAIDEN NAME: BETTY STEWART

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Prematurity	Birth
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hyd Calculus	2 days
	(c)	

764.5
159

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 31, 19 50, to Sept 15, 19 50, that I last saw the deceased alive on Sept 14, 19 50, and that death occurred at m., from the causes and on the date stated above.

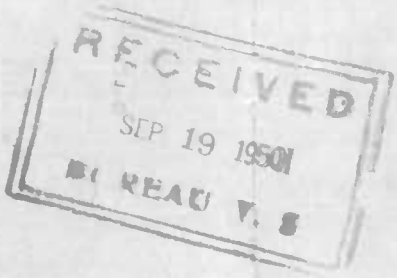
SIGNATURE: F. N. Ellison MD (Degree or title) ADDRESS: 126 Vance St. Cumberland Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 16 1950	Hebron Cemetery	Romney, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 15, 1950	Hiriter L. Hartz M.D.	Meryl S. Combs	Romney, W. Va.

(Combs)

19V3109991


RECEIVED
SEP 19 1950
BUREAU

Dr. W. F. Williams

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08847

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

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VS. A15 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 32 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lillian	B.	Martin	9	24	19 50

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Married	6-12-06	44 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benjamin Miller	Mary Alice Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Memorial Hospital, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Hypertensive Cardio	
442X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 131a	(b) Vascular Renal Disease	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 8-4-, 19 50, to 9-24-, 19 50, that I last saw the deceased alive on 9-23-, 1950, and that death occurred at 5:12 a.m., from the causes and on the date stated above.

SIGNATURE: W. F. Williams (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 9-25-50.

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	9/27/50	Phlox	Westernport	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 26, 1950	Grates R. Frantz, M.D.	C. L. Bell	Westernport Md.

RECEIVED
OCT 3 1950
BUREAU Y. S

08848

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL Cresaptown ~~Cumberland~~ LENGTH OF STAY (in this place) 50 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Winchester Rd. RFD #5

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL Cresaptown ~~Cumberland~~
STREET ADDRESS (If rural, give location) Winchester Rd. RFD #5

3. NAME OF DECEASED (Type or Print) (First) Peter (Middle) Martin (Last) Martz

4. DATE OF DEATH (Month) Sept (Day) 26 (Year) 1950

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH Dec 29 1870 | 9. AGE last birthday 79 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman | 10b. KIND OF BUSINESS OR INDUSTRY Rail way | 11. BIRTHPLACE (State or foreign country) Allegany Co. Md | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Peter Martz | 14. MOTHER'S MAIDEN NAME Olie Wigger.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS Julius Martz. Cresaptown Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Encephalomalacia — INTERVAL BETWEEN ONSET AND DEATH 10 day

332x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) cerebral arteriosclerosis

83c (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November, 1940, to 9/26, 1950, that I last saw the deceased alive on 9/22, 1950, and that death occurred at 8 30 A m., from the causes and on the date stated above.

SIGNATURE Elizabeth Billings (Degree or title) M.D. ADDRESS 55 Greene St. DATE SIGNED 9/27/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Sept 29 50 | NAME OF CEMETERY OR CREMATORY St Ambrose Cem | LOCATION (City, town, or county) Cresaptown (State) Md.

DATE REC'D BY LOCAL REG. Sept. 28, 1950 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR Louis Stein Inc. ADDRESS Cumberland

98847

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
OCT 9 1950
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08849

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg, Md
LENGTH OF STAY (in this place): Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): Grant Street

3. NAME OF DECEASED (Type or Print): George Emmett McAteer
4. DATE OF DEATH: (Month) 9 (Day) 3 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 9/5/1885
9. AGE last birthday: 64 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker of Pumps
10b. KIND OF BUSINESS OR INDUSTRY: Piney Run Dam
11. BIRTHPLACE (State or foreign country): Frostburg, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James McAteer
14. MOTHER'S MAIDEN NAME: Mary Tipping

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 220-10-1913
17. INFORMANT AND ADDRESS: Henry Edward McAteer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Arrhosis of Liver — Interval between onset and death: 6 wks

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chr Myocarditis — 8 mo

422.2
124b

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1950, to Sept 3, 1950, that I last saw the deceased alive on Sept 3, 1950, and that death occurred at 130 P m., from the causes and on the date stated above.

SIGNATURE: Wm McLane MD (Degree or title) — ADDRESS: Frostburg Md — DATE SIGNED: 9-5-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 9/6/50
NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery
LOCATION (City, or county) (State): Frostburg Md.

DATE REC'D BY LOCAL REG. 9-6-50
REGISTRAR'S SIGNATURE: Mrs Nancy H. Roe
24. FUNERAL DIRECTOR — ADDRESS: Jacob Hafer, 23 E. Main, Frostburg, Md.

602 SV

RECEIVED
SEP 11 1950
BUREAU V. S.

Within corporate limits

08850

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 2 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	STREET ADDRESS (If rural, give location) 508 N. Mechanic Street

3. NAME OF DECEASED (Type or Print)	(First) Janet	(Middle) Corrine	(Last) Means	4. DATE OF DEATH	(Month) ~~August~~ September (Day) 7th (Year) 1950
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W.	8. DATE OF BIRTH 4/2/1881	9. AGE last birthday 69 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Elizebeth Poffenberger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. ?	17. INFORMANT Mrs. Vivian Valella			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Strangulated Left Femoral Hernia. duration 5 days

561.5 Antecedent cause(s)

122a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 9-5-50	19b. MAJOR FINDINGS OF OPERATION Strangulated small bowel	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-2-50, 19....., to 9-7-50, 19....., that I last saw the deceased alive on 9-7-50, 19....., and that death occurred at 5:25 AM m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

[signature] Cumberland Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Sept. 10 50	NAME OF CEMETERY OR CREMATORY Davis Cemetery	LOCATION (City, town, or county) (State) Davis, W.Va.
DATE REC'D BY LOCAL REG. Sept 10 1950	REGISTRAR'S SIGNATURE Winter R. Trantz, M.D.	24. FUNERAL DIRECTOR Wayne A. Spiggle	ADDRESS Davis, W.Va

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
SEP 19 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08851

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Maryland
STREET ADDRESS (If rural, give location) REAR 460 Walnut St

3. NAME OF DECEASED (Type or Print): (First) Laura (Middle) (Last) Meese
4. DATE OF DEATH: (Month) 9 (Day) 30 (Year) 1950
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 5-17-63
9. AGE last birthday: 87 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Allegany County, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Meese
14. MOTHER'S MAIDEN NAME: Sarah Appleton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Blanche Meese Tiffin, Ohio

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (a)	Myocardial failure	7 hrs
420.1 Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Coronary Sclerosis	3 yrs
(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 6, 1950, to Sept. 30, 1950, that I last saw the deceased alive on Sept. 29, 1950, and that death occurred at 8:55 p m., from the causes and on the date stated above.

SIGNATURY (Degree or title) ADDRESS DATE SIGNED
Arthur J. Jones M.D. 110 S. Centre St. Oct. 2, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: Oct 3, 50 | NAME OF CEMETERY OR CREMATORY: Rose Hill Cem | LOCATION (City, town or county): Cumberland (State): Md

DATE REC'D BY LOCAL REG.: Oct. 3, 1950 | REGISTRAR'S SIGNATURE: Walter R. Dantz, M.D. | 24. FUNERAL DIRECTOR: Louis Stein Inc ADDRESS: "

RECEIVED
OCT 9 1950
BUREAU W. S.

DR. ELIASON

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08852

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE PENNSYLVANIA COUNTY BEDFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BEDFORD, PA. ROUTE # 3
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) ALLEN (Middle) LEE (Last) MILLER
4. DATE OF DEATH (Month) SEPT. (Day) 15. (Year) 1950
5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE
8. DATE OF BIRTH JULY 20, 1950
9. AGE last birthday ~~WEEKS~~ Sxxx If under 1 year Months 1 Days 25 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JAMES R. MILLER
14. MOTHER'S MAIDEN NAME ROSE E. WEYANT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL- CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Extrophy of Bladder (Congenital)	Birth
757.3 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Ileo Colitis	5 days
119a	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-6, 1950, to 9-14, 1950, that I last saw the deceased alive on 9-14, 1950, and that death occurred at 4:20 Am., from the causes and on the date stated above.

SIGNATURE H. Eliason (Degree or title) ADDRESS 126 Union St. Cumberland Md DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9-16-50
NAME OF CEMETERY OR CREMATORY P. O. S. of A.
LOCATION (City, town, or county) (State) Centreville, Pa
DATE REC'D BY LOCAL REG. Sept. 15, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR S. A. Barefoot - Bedford, Pa. ADDRESS

9V7200 99V99V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 19 1950
BUREAU T. I

08853

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hoffman Mine (rural) | LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.#1 Frostburg,Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hoffman Mine (rural)
STREET ADDRESS (If rural give location) R.F.D.#1 Frostburg,Md.

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) Van Meter (Last) Mills

4. DATE OF DEATH: (Month) Sept. (Day) 22 (Year) 19 50

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: April-12-1886

9. AGE last birthday: 64 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter

10b. KIND OF BUSINESS OR INDUSTRY: building

11. BIRTHPLACE (State or foreign country): W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Kenneth Mills

14. MOTHER'S MAIDEN NAME: Ellen Sperlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Memorial Hospital record.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Pulmonary embolism (massive) due to	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	injury to chest wall	about 22 days
	(c)		

8450
171b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY home | (CITY OR TOWN) near Frostburg,Md | (COUNTY) Allegany | (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) Aug. 31/50 (Hour) 7.30 P. m. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? Driving horse & wagon wagon turned over & injured chest.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland,Md. Sept.27-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF 9-27-50 | NAME OF CEMETERY OR CREMATORY Eckhart Cemetery | LOCATION (City, town, or county) (State) Eckhart. Md.

DATE REC'D BY LOCAL REG. 9-28-50 | REGISTRAR'S SIGNATURE Mrs. Nancy A. Roe | 24. FUNERAL DIRECTOR ADDRESS Jacob Hafer. Frostburg. Md.

30849

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08854

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing | LENGTH OF STAY (in this place) 30 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural give location) Island Street

3. NAME OF DECEASED (Type or Print): (First) Ebenezer (Middle) (Last) Moore
4. DATE OF DEATH: (Month) Sept (Day) 11 (Year) 19 50

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED OR DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 20, 1884
9. AGE last birthday: 66 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY: Church
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Moore
14. MOTHER'S MAIDEN NAME: Mary Ann Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Harry Chappell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic nephritis	2 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocarditis	6 mo
	(c)	

4122.2
1312

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1948, to Sept 11, 1950, that I last saw the deceased alive on Sept 11, 1950, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE: E Berry | (Degree or title) M.D. | ADDRESS Piedmont | DATE SIGNED W. Va

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Sept 14, 1950 | NAME OF CEMETERY OR CREMATORY: Laural Hill Cemetery | LOCATION (City, town, or county): Moscow | (State): Md

DATE REC'D BY LOCAL REG. 9-14-50 | REGISTRAR'S SIGNATURE: Jeanette M Boal

24. FUNERAL DIRECTOR: M. Eichhorn | ADDRESS: Lonaconing, Md.

74094

RECEIVED
SEP 18 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

08855

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: near (rural) Frostburg
LENGTH OF STAY (in this place): about 1/2hr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Swimming Pool

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Pa. COUNTY: Sommerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Wellersburg
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Robert	E.	Neubiser	Sept.	4	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
male	white	single	May 3-1939	11 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	school	Wellersburg Pa.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Louis Neubiser	Wilhlemine Witt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	-----	father

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
909.4 **Immediate cause**	(a) Asphexia due to drownding	about 3 minutes
183 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	Swimming Pool	near Frostburg	Allegany	Md.

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☒	HOW DID INJURY OCCUR?
Sept. 4/50 2.45 P. m.		in swimming, presume cramp, caused drownding.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.		Cumberland, Md.	Sept.4-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/8/1950	Wellersburg Cemetery	Wellersburg Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-6-50	Mrs. Nancy N. Roe	Harvey A. Leigler	Hyndman, Pa.

RECEIVED
SEP 11 1950
BUREAU OF I

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

08856

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 46yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS I4 Virginia Ave	STREET ADDRESS (If rural, give location) I4 Virginia Ave.

3. NAME OF DECEASED (Type or Print)	(First) Walter	(Middle) W.	(Last) Parker	4. DATE OF DEATH	(Month) (Day) (Year) 9/I2/50 19
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 26, I877	9. AGE last birthday 73 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Him Self	11. BIRTHPLACE (State or foreign country) Romney W.Va.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John W. Parker	14. MOTHER'S MAIDEN NAME Verlinda M. Lingo				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS Laura Virginia Parker Cumberland, Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uraemia	2 wks.
422.2 Antecedent cause(s)	(b) Myocarditis c̄ Dilatation	2 yrs.
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 15, 1950, to Sept. 12, 1950, that I last saw the deceased alive on Sept. 12, 1950, and that death occurred at 9:55 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Clay R. Durrett	M. D.	Cumberland	9/12/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 9/I4/50	NAME OF CEMETERY OR CREMATORY Rose Hill Cem.	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. Sept. 13, 1950	REGISTRAR'S SIGNATURE Walter R. Frantz M.D.	24. FUNERAL DIRECTOR James F. Scarpelli	ADDRESS Cumberland, Md.

30809

RECEIVED
SEP 19 1950
BUREAU V. S

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

08857

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 227 Henderson Avenue

3. NAME OF DECEASED (Type or Print): (First) Sophia (Middle) (Last) Paupe

4. DATE OF DEATH: (Month) 9 (Day) 2 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: May 25, 1859

9. AGE last birthday: 91 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland Cumberland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Adam Ritter

14. MOTHER'S MAIDEN NAME: Elizabeth Ewald

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Russell Paupe (Son), City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	6 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	6 yrs
	(c)	

420.1
9da

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 30, 1950, to Sept. 2, 1950, that I last saw the deceased alive on Aug 31, 1950, and that death occurred at 4:25 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur F. Jones M. D. 110 S. Centre St. Sept. 3 1950

23. BURIAL, CREMATION, REMOVAL (Specify) DATE: Burial Sept. 4, 1950

NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Sept. 4, 1950

REGISTRAR'S SIGNATURE: Walter L. Mark, M.D.

24. FUNERAL DIRECTOR: John W. Hafer

ADDRESS: Cumberland Md.

RECEIVED
SEP 15 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08858

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): MARYLAND 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 219 Carroll St.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Pindol (Last) Phares

4. DATE OF DEATH: (Month) Sept (Day) 11 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: Feb 11 1878

9. AGE last birthday: 72 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): Elkins W. Va.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Johnson W. Phares

14. MOTHER'S MAIDEN NAME: Elizabeth Ward.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Sephronia Collette, Elkins, W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) Cerebral vascular accident — Interval Between Onset and Death: 2 days

830 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) General Arteriosclerosis — 4 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 29, 1950, to Sept. 11, 1950, that I last saw the deceased alive on Sept. 9, 1950, and that death occurred at 11:50 P.m., from the causes and on the date stated above.

SIGNATURE: Arthur F. Jones (Degree or title) M.D. ADDRESS: 110 S. Centre St DATE SIGNED: Sept. 12, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 9/13/50
NAME OF CEMETERY OR CREMATORY: Maplewood Cem
LOCATION (City, town, or county) (State): Elkins W. Va

DATE REC'D BY LOCAL REG.: Sept. 12, 1950
REGISTRAR'S SIGNATURE: Hunter R. Trout M.D.

24. FUNERAL DIRECTOR ADDRESS: John J. Hafer, Cumberland, Md.

36249

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SEP 18 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08859

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Algonquin Hotel Washington Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): Washington Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Harry	Austin	Pitzer	Sept	26	19 50

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months / Days	If under 24 hrs. Hours / Min.
Male	White	Married	Oct. 31, 1873	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bank President	1st Nat. Bank	Cumberland, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Pitzer	Amanda Elder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	217-14-4013	Mrs. Theodosia Pitzer, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — Very

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Arteriosclerosis — Short

420.1
117b

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Duodenal Ulcer (Obstructing)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 9-25, 1950, to 9-26, 1950, that I last saw the deceased alive on 9-25 1950, and that death occurred at 12 noon m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. L. Williams	M.D.	Cumberland	9-26-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 29, 1950	Rose Hill Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 29, 1950	Walter L. Lantz, M.D.	William H. Kight	Cumberland Md.

15684

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OCT 3 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

08860

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND; LENGTH OF STAY (In this place) 6 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Westernport, Md; STREET ADDRESS (If rural give location) R.F.D #3 Keyser W.Va.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) P. (Last) Popp

4. DATE OF DEATH: (Month) Sept. (Day) 27 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: March 5-1892

9. AGE last birthday: 58 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer for W.Va. Pulp & Paper Co

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Popp

14. MOTHER'S MAIDEN NAME: Katherine Wilt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I

16. SOCIAL SECURITY NO. 217-05-1387

17. INFORMANT: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Leukemia — Interval between onset and death: ?

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 204.4 (c) 74a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [X] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: INJURY OCCURRED While at work [ ] Not while at work [ ]; HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy [X] Inspection [X], Inquiry [X] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D.	H.V. Deming M.D.	Cumberland, Md.	Sept. 27-1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 30. 50	Phalos	Westernport. Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 29, 1950	Walter K. Dantz, M.D.	Ellsworth S. Boal	Westernport, Md. 98811

RECEIVED
OCT 3 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

08861

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing; MARYLAND; LENGTH OF STAY (In this place): 76 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 68 W,Main St,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md, COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing; STREET ADDRESS (If rural give location): 68 W,Main St,

3. NAME OF DECEASED (Type or Print): (First) Agnes (Middle) (Last) Reed

4. DATE OF DEATH: (Month) Sept, (Day) 6 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: June 22,1873

9. AGE last birthday: 77 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Giard Ill

12. CITIZEN OF WHAT COUNTRY? U,S,A,

13. FATHER'S NAME: Alexander McKenzie

14. MOTHER'S MAIDEN NAME: Margaret Wilsen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs,Margaret Arnold

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	at onc
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c) Arteriosclerosis	?

420.1 94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Rheumatism — 1 yr.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒**

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒* Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒*, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H,V,Deming M,D, H.V. Deming M.D.	Cumberland Md,	Sept,6,1950

23. BURIAL, CREMATION or REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept 9 1950	Oak Hill Cemetery	Lonaconing Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-9-50	Jeannette M Beal	M.Eichhorn	Lonaconing, Md.

VS. A15A

RECEIVED
SEP 18 1950
BUREAU V. S

DR. W.F.WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08862

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY ALLEGANY — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD.
LENGTH OF STAY (in this place): 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND (RURAL)
STREET ADDRESS (If rural, give location): RT.#1, ALLEGANY GROVE

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE	W.	REMER	SEPT.	22	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	MARRIED	8/31/1900	50 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
DISTRICT MANAGER	INSURANCE CO.	MISSOURI	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM H. REMER	KATHERINE FERBER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
yes	War I		MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X — **Immediate cause** (a) Cerebral Hemorrhage

83a — **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: From 9-21-50 to Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9-21, 19 50, to 9-22, 19 50, that I last saw the deceased alive on 9-22, 19 50, and that death occurred at 10:50 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. F. Williams M.D. Cumberland 9-22-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal & Burial	Sept 23 50	Pleasantville Cem.	Atlantic City N.J.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR, ADDRESS
Sept. 23, 1950	Walter A. Wantz, M.D.	Louis Stein Inc Cumberland Md

156 50

4327

RECEIVED
SEP 26 1950
BUREAU T. S

DR. DYER

Within corporate limits

08863

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 32 WEST OLDTOWN ROAD

3. NAME OF DECEASED (Type or Print): (First) BABY BOY (Middle) #1 Twin (Last) ROBINETTE

4. DATE OF DEATH: (Month) SEPT. (Day) 26 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: SEPT. 26, 1950

9. AGE last birthday: yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours 14, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland MEMORIAL HOSPITAL

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: HELEN ROBINETTE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: HELEN ROBINETTE 32 WEST OLDTOWN RD. CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Premature birth - 6½ mo. — INTERVAL BETWEEN ONSET AND DEATH: 14 hrs.

776X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

159 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-26, 1950, to 9-26, 1950 that I last saw the deceased alive on 9-26, 1950, and that death occurred at 10 P m., from the causes and on the date stated above.

SIGNATURE John A Dyer (Degree or title) MD — ADDRESS 247 Vale Ave — DATE SIGNED 9-27-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF Sept. 28, 1950 — NAME OF CEMETERY OR CREMATORY Oldtown Cemetery — LOCATION (City, town, or county) (State) Oldtown, Maryland

DATE REC'D BY LOCAL REG. Sept. 27, 1950 — REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR Mrs. Eva Robinette Johnson — ADDRESS Grandmother Wiley Ford, West Virginia

2-1-9-26-0-25-6-24-1

M

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The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 3 1960
BUREAU V. S.

Within corporate DR. DYER

08864

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND,
STREET ADDRESS (If rural, give location) 32 WEST OLDTOWN ROAD,

3. NAME OF DECEASED (Type or Print) (First) BABY (Middle) BOY # 2, (Last) ROBINETTE
4. DATE OF DEATH (Month) SEPT. (Day) 27 (Year) 1950
5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH SEPT. 26, 1950
9. AGE last birthday yrs. If under 1 year Months 1 Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland MEMORIAL HOSPITAL
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME HELEN ROBINETTE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS HELEN ROBINETTE 32 WEST OLDTOWN RD CUMBERLAND, MD. ~~XXXXXX~~

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Premature birth - 6 1/2 mo — INTERVAL BETWEEN ONSET AND DEATH 1 da.

776X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

159 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-26, 1950, to 9-27, 1950, that I last saw the deceased alive on 9-27, 1950, and that death occurred at 6:20 P.m., from the causes and on the date stated above.

SIGNATURE John A. Dyer, MD. (Degree or title) ADDRESS 247 Va ave DATE SIGNED 9-28-50

23. BURIAL, CREMATION REMOVAL (Specify) Cremine
DATE THEREOF Sept. 28, 1950
NAME OF CEMETERY OR CREMATORY Oldtown Cemetery
LOCATION (City, town, or county) (State) Oldtown, Maryland

DATE REC'D BY LOCAL REG. Sept. 28, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Mrs. Eva Robinette Johnson, Grandmother
ADDRESS Wiley Ford, West Virginia

2-1-9-26-0-25-7-24-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
OCT 3 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

08865

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

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VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (In this place): 20 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: (In garage) 824 Shriver Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 824 Shriver Ave.

3. NAME OF DECEASED (Type or Print): (First) Duncan (Middle) Walter (Last) Root
4. DATE OF DEATH: (Month) Sept. (Day) 24 (Year) 1950
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: March 22-1878
9. AGE last birthday: 72 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired merchant
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): Close Mt. (Tucker Co) W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: David E Root
14. MOTHER'S MAIDEN NAME: Margaret Close
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 714-05-6584
17. INFORMANT: Rose Dawson Root

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Asphyxia due to hanging. (suicide) — Interval between onset and death: about 5 min.

974X
164a
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. Sept. 25-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Sept 27 50
NAME OF CEMETERY OR CREMATORY: Hillcrest Cem
LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Sept. 27, 1950
REGISTRAR'S SIGNATURE: Walter K. Kantz, M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc
ADDRESS: " "

15661

RECEIVED
OCT 3 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08866

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH · COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Midland
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Baby Girl (Middle) (Last) Rounds

4. DATE OF DEATH: (Month) September (Day) 9 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify):

8. DATE OF BIRTH: 7 September 50

9. AGE last birthday: yrs. If under 1 year ~~Months~~ Days: 2 Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Minor Rounds

14. MOTHER'S MAIDEN NAME: Wellie Wilt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Minor Rounds

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

Immediate cause (a) Meningocoele (Spinal Bifida) — Interval between onset and death: 2 days

752x Antecedent cause(s)

157a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Lumbar area c Continual leaking of Spinal fluid — 2 days

(c) Hydrocephalis -

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 Sept., 1950 to 9 Sept., 1950, that I last saw the deceased alive on 9 Sept 1950, and that death occurred at 2 55 P E.S.T. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John B. Davis, M.D. Frostburg, Md. 9/9/50.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 10 Sept. 1950 — NAME OF CEMETERY OR CREMATORY: Methodist Cemetery — LOCATION (City, town, or county) (State): New Germany, Garrett Co., Md.

DATE REC'D BY LOCAL REG. 9-10-50 — REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe — 24. FUNERAL DIRECTOR ADDRESS: M. Eichhorn, Lonaconing, Md.

2-0-9-07-0-24-3-40-4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 14 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08867

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 3 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 56 Spring St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 56 Spring St

3. NAME OF DECEASED (Type or Print): (First) Martha (Middle) E. (Last) Saburg

4. DATE OF DEATH: (Month) 9 (Day) 24 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Apr 14 1892

9. AGE last birthday: 58 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Frostburg Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Lorenz

14. MOTHER'S MAIDEN NAME: Catherine Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Harry Saburg Rt. 1 Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 4 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — 2 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948, 19..., to Sept 24, 1950, that I last saw the deceased alive on Sept 23, 1950, and that death occurred at 1:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm Lane MD ADDRESS Frostburg Md DATE SIGNED 9-25-50

23. BURIAL, CREMATION / REMOVAL (Specify) Burial; DATE THEREOF 9-27-1950; NAME OF CEMETERY OR CREMATORY Frostburg Memorial; LOCATION (City, town, or county) Frostburg; (State) Md.

DATE REC'D BY LOCAL REG. 9-26-50; REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR Jacob Siegel; ADDRESS Frostburg Md.

RECEIVED
SEP 28 1950
BUREAU V. S

Within corporate limits DR. W. F. WILLIAMS

08868

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND MD.
LENGTH OF STAY (in this place) 7 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY MINERAL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PATTERSON CREEK
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) KATE (Middle) (Last) SHOBE

4. DATE OF DEATH (Month) SEPT. (Day) 13 (Year) 1950

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED

8. DATE OF BIRTH AUGUST 8 1882

9. AGE last birthday 78 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME WILLIAM E. BAKER

14. MOTHER'S MAIDEN NAME MARY SUSAN DELAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.2 Immediate cause (a) Chronic Myocardial

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Degeneration

93d (c) Infirmities of age

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-6, 1950 to 9.13, 1950 that I last saw the deceased alive on 9-12, 1950, and that death occurred at 1:05 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. F. Williams M.D. Cumberland 9-13-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 9/15/50

NAME OF CEMETERY OR CREMATORY Maple Hill

LOCATION (City, town, or county) Petersburg (State) W. Va.

DATE REC'D BY LOCAL REG. Sept. 14, 1950

REGISTRAR'S SIGNATURE Winter R. Frantz M.D.

24. FUNERAL DIRECTOR E. B. Thursh Petersburg, W. Va. by Rosie Halltman

ADDRESS

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

9-6-50
9-13-50

1105

Within corporate limits

08869

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 11 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Cumberland Rural
STREET ADDRESS (If rural give location) R.F.D.#5 Braddock Road.

3. NAME OF DECEASED (Type or Print) (First) George (Middle) Lewis (Last) Sisk
4. DATE OF DEATH (Month) Sept. (Day) 20 (Year) 1950

5. SEX Male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH April 20-1876
9. AGE last birthday 74 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper hanger & Plaster
10b. KIND OF BUSINESS OR INDUSTRY for self
11. BIRTHPLACE (State or foreign country) Claysville W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Sisk
14. MOTHER'S MAIDEN NAME Harriet Fetters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs.A.Pearl Edwards Sisk

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
331X	Immediate cause	(a) Cerebral hemorrhage (apoplexy)	about 18 hrs
83a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	?
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland,Md. DATE SIGNED Sept 20-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9-23-1950
NAME OF CEMETERY OR CREMATORY Fort Ashby Cem.
LOCATION (City, town, or county) (State) Fort Ashby, W. Va.

DATE REC'D BY LOCAL REG. Sept. 22, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland,Md.

49611

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 26 1950
BUREAU OF S

Within corporate limits

08870

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 37 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS: in back yard at 100 Mullin St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural give location): 100 Mullin St.

3. NAME OF DECEASED (Type or Print): (First) Albert [redacted] (Middle) Elmer (Last) Smith

4. DATE OF DEATH: (Month) Sept. (Day) 30 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: June 26-1874

9. AGE last birthday: 76 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Everett, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John H. Smith

14. MOTHER'S MAIDEN NAME: Eliza Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT: John E Matthews, Brother-in-law

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute dilatation of the heart due to over	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) exertion, had chronic myocarditis with hypertrophy and arteriosclerosis (marked)	several
	(c) with hypertention.	years.

443x
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

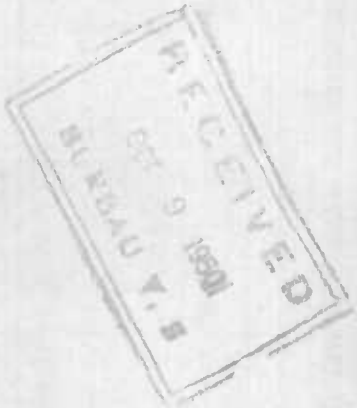
SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V. Deming M.D. H. V. Deming M.D. Cumberland, Md. Sept. 30-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Oct. 3, 1950 | NAME OF CEMETERY OR CREMATORY: Mt. Herman Cem. | LOCATION (City, town, or county) (State): Near Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct 2 1950 | REGISTRAR'S SIGNATURE: Wade K. Kantz, M.D. | 24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md. | ADDRESS

30879


RECEIVED
OCT 9 1901
BUREAU V.S

Within corporate limits

M

08871

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 43 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Windsor Hotel

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) Windsor Hotel

3. NAME OF DECEASED (Type or Print) (First) Carl (Middle) William (Last) Smith

4. DATE OF DEATH (Month) Sept. (Day) 3 (Year) 1950

5. SEX Male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH Feb.1-1907

9. AGE last birthday 43 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman for Lou Auto Parts

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lawrence Edward Smith

14. MOTHER'S MAIDEN NAME Emily Lauderback

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 214-05-8119

17. INFORMANT John Ed. Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage due to a 22 caliber	5 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) rifle bullet in brain, (suicide.)	
	(c)	

976X
164c

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Windsor Hotel (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) Sept3/50 125A m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Shot himself.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Sept.3-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Sept.5,1950

NAME OF CEMETERY OR CREMATORY Trinity Lutheran

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Sept. 5, 1950

REGISTRAR'S SIGNATURE Winter R. Frantz M.D.

24. FUNERAL DIRECTOR H. Wayne George ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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29869

RECEIVED
SEP 15 1950
BUREAU V. S

Within corporate limits

08872

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 313 Independence St.

3. NAME OF DECEASED (Type or Print) (First) Baby (Middle) Boy (Last) SNYDER

4. DATE OF DEATH (Month) (Day) (Year) 9-12-1950 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Infant
8. DATE OF BIRTH 9-12-1950
9. AGE last birthday 0 yrs. If under 1 year Months 0 Days 0 If under 24 hrs. Hours 2 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John Snyder
14. MOTHER'S MAIDEN NAME Iva Ford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS John Snyder Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

761.5 Immediate cause (a) premature baby (2 lbs 12 ounces)

1600 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) placenta previa of mother

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-12-, 1950, to 9-12-, 1950, that I last saw the deceased alive on 9-12-, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) L Wrings (MD) ADDRESS 51 Greene St. Cumberland DATE SIGNED 9-13-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9-14-1950
NAME OF CEMETERY OR CREMATORY Zion Memorial
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Sept. 14, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

2-0-9-12-0-35-5-26-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 19 1960
BUREAU V. S

Within corporate limits

DR. W.F.WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08873

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, M — LENGTH OF STAY (in this place) 49yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND,
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 26 VIRGINIA AVE.,

3. NAME OF DECEASED (Type or Print)	(First) JEREMIAH	(Middle) C.	(Last) SPRING	4. DATE OF DEATH	(Month) SEPT.	(Day) 18 (Year) 1950
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MARCH 6/1885	9. AGE last birthday 65 yrs.	If under 1 year Months / Days	If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Engineer	10b. KIND OF BUSINESS OR INDUSTRY Locomotive R.R.Co	11. BIRTHPLACE (State or foreign country) Great Cacapon W.Va.	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ADAM SPRING	14. MOTHER'S MAIDEN NAME RHODA ZILER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 705-0706889	17. INFORMANT AND ADDRESS Mrs Grace Spring 26 Virginia Ave.				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

154X Immediate cause (a) Left Bundle Branch Block

46d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Metastatic Carcinoma of

(c) Spine & thoracic Contents.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 3.29.46	19b. MAJOR FINDINGS OF OPERATION Adeno Carcinoma Pelvis abdominal rectum resection	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8.20., 1950, to 9-18-, 1950, that I last saw the deceased alive on 9.18., 1950, and that death occurred at 6:05 Am., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W.F. Williams	M.D.	Cumberland	9-18-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/20/50	Rose Hill Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 19, 1950	Winter R. Hantz, M.D.	James F. Scarpelli	Cumberland, Md.

32247

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
SEP 26 1950
BUREAU V. S

Dr. L. Brings

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08874

1454

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 327 Bedford St

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Baby Boy Thomas
4. DATE OF DEATH (Month) (Day) (Year): Sept 29 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept 28/50
9. AGE last birthday: yrs. — If under 1 year: Months / Days: 1 — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Donald Thomas
14. MOTHER'S MAIDEN NAME: Leona Bennett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Donald Thomas Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) prematurity — 1 day

776X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

159 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 6 months — fetus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-28, 1950, to 9-29, 1950, that I last saw the deceased alive on 9-29, 1950, and that death occurred at 4 15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): L Brings MD — ADDRESS: 57 Greene St. — DATE SIGNED: 9-28-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 9-30-1950
NAME OF CEMETERY OR CREMATORY: Greenmont Cemetery
LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Sept. 30, 1950
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: Wm H Right — ADDRESS: Cumberland Md

2 0-9-28-0-26-3-24-0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 3 1950
BUREAU V.

Within corporate limits

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08875

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 606 Virginia Ave.

3. NAME OF DECEASED (Type or Print) (First) Chauncey (Middle) Van Osdale (Last)
4. DATE OF DEATH (Month) Sept (Day) 20 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH About 1.8 Unknown
9. AGE last birthday 63 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Clerk Retired - B. and O. R. R. Co
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Silas Van Osdale
14. MOTHER'S MAIDEN NAME Martha Alderton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Mrs. Mattie B. Van Osdale, Brunswick, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Cardiac Decompensation	3 wks.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Coronary Sclerosis	1 yr.
	(c)		

420.1
95C

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-30, 1950, to 9-20, 1950, that I last saw the deceased alive on 9-20, 1950, and that death occurred at 5 A. m., from the causes and on the date stated above.

SIGNATURE John A. Dyer (Degree or title) MD. ADDRESS 247 Va Ave DATE SIGNED 9-22-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept. 24
NAME OF CEMETERY OR CREMATORY Park Heights Cem.
LOCATION (City, town, or county) Brunswick (State) Md

DATE REC'D BY LOCAL REG. Sept. 22, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR C. H. Feete & Son, Brunswick, Md. ADDRESS

26647

RECEIVED
SEP 26 1950
BUREAU V. S

Outside of City Limits

08876

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Vale
LENGTH OF STAY (in this place) 55 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4 Weires Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Vale
STREET ADDRESS (If rural, give location) 4 Weires Ave

3. NAME OF DECEASED (Type or Print) (First) Christopher (Middle) (Last) Weires

4. DATE OF DEATH (Month) September (Day) 24 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 22, 1875
9. AGE last birthday 75 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farming
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) Wellersburg, Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Weires
14. MOTHER'S MAIDEN NAME Alice Wryden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT Walter Weires, Son - Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of liver — INTERVAL BETWEEN ONSET AND DEATH 18 mo

156.1 Antecedent cause(s)

46f Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) no
PLACE (Home, ~~farm, factory, street~~, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1949, to Sept 24, 1950, that I last saw the deceased alive on Sept 24, 1950, and that death occurred at 11 a m., from the causes and on the date stated above.

SIGNATURE L. M. Maskews Jr. (Degree or title) ADDRESS 49 Green St Cumberland, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Sept 26, 1950
NAME OF CEMETERY OR CREMATORY Greenmount Cem
LOCATION (City, town, or county) Cumberland, Md (State)

DATE REC'D BY LOCAL REG. Sept. 26, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md ADDRESS

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 8 1950
BUREAU V. S.

Within corporate limits

08877

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 20 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 716 Fayette St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 767 Greene St.

3. NAME OF DECEASED (Type or Print) (First) Ella (Middle) B. (Last) Wilson
4. DATE OF DEATH (Month) Sept (Day) 11 (Year) 1950
5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH July 13, 1863
9. AGE last birthday 87 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Flintstone, Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel Wolford
14. MOTHER'S MAIDEN NAME Amanda Willison
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Dr. A. G. T. Twigg, 767 Greene St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Stomach

151X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

46b

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1950, to Sept, 19....., that I last saw the deceased alive on 11, 1950, and that death occurred at 11 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

[signature] Cumberland Sept 12 50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept 13, 1950
NAME OF CEMETERY OR CREMATORY IOOF Cemetery
LOCATION (City, town, or county) near Flintstone (State) Md.

DATE REC'D BY LOCAL REG. Sept. 13, 1950
REGISTRAR'S SIGNATURE Walter R. Hanks, M.D.
24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md. ADDRESS

RECEIVED
SEP 19 1950
BUREAU U. S

Within corporate limits DR. MURRAY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08878

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
MARYLAND
LENGTH OF STAY (In this place): 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEG.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: MT. SAVAGE
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) BABY BOY (Middle) (Last) WINEBRENNER

4. DATE OF DEATH: (Month) SEPT (Day) 1 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE

8. DATE OF BIRTH: AUG. 30, 1950

9. AGE Last birthday: ____ yrs. If under 1 year: Months ____ Days 2 If under 24 hrs.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GUS WINEBRENNER

14. MOTHER'S MAIDEN NAME: DOROTHY MACHIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

7955 public

Immediate cause (a) ____

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Prematurity.

(c) ____

INTERVAL BETWEEN ONSET AND DEATH: 2 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 31, 1950, to Sept 1, 1950, that I last saw the deceased alive on ____, 19____, and that death occurred at 5:25 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title): B. M. Schindler M.D. ADDRESS: 41 Decatur St Cumberland Md DATE SIGNED: Sept 1, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Sept 1, 1950

NAME OF CEMETERY OR CREMATORY: St. George's Cemetery

LOCATION (City, town, or county) (State): Mt. Savage, Maryland

DATE REC'D BY LOCAL REG.: Sept. 1, 1950

REGISTRAR'S SIGNATURE: Wister K. Manly, M.D.

24. FUNERAL DIRECTOR: J. J. Durst, Frostburg, Maryland ADDRESS:

2-6-8-30-0-3-7-2-4-0-4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 6 1950
BUREAU V. S

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

08879

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 223 South Mechanic St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 223 South Mechanic St

3. NAME OF DECEASED (Type or Print) (First) Carl (Middle) Edward (Last) Wintermeyer

4. DATE OF DEATH (Month) Sept. (Day) 20 (Year) 1950

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH Aug. 5-1897

9. AGE last birthday 53 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Acetate Dept.

10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp. of Am.

11. BIRTHPLACE (State or foreign country) (Cash Valley near Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John W. Wintermeyer

14. MOTHER'S MAIDEN NAME Ella A. Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.1

16. SOCIAL SECURITY NO. 220-10-8729

17. INFORMANT Lena Davis Wintermeyer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary sclerosis	at once
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
94a	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V. Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Sept. 21-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Sept 23 50 NAME OF CEMETERY OR CREMATORY Gwn Mem. Cem LOCATION (City, town, or county) Rural Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Sept. 22, 1950 REGISTRAR'S SIGNATURE Winter K. Frantz M.D. 24. FUNERAL DIRECTOR Louis Stein Ins. ADDRESS " "

XVX 16

RECEIVED
SEP 26 1950
BUREAU V. S

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

08880

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, Rt route to Memorial Hospital
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Cumberland, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: W.Va. — COUNTY: Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Points
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Russell	Eugene	Wolford	Sept.	30	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	white	single	June 29 1929	21 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer apple picker	Orchard	W.Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Lawrence Wolford	Lylia Foltz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	723-14-6851	Harold Wolford

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Sub dural hemorrhage due to a fracture of	?
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) the skull, from automobile accident	
	(c)	

819.5
170 c

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	highway	near Green Spring	Hampshire	W.Va.

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☒	HOW DID INJURY OCCUR?
Sept. 30/50 6.P.m.		Front wheel locked ran into bank & turned over.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: naturol causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland, Md.	Sept. 30-1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 3 1950	Walick Cemetery	Augusta, W.Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 1, 1950	Winter R. Frantz M.D.	W.N. McKee, Augusta, W.Va.	

988 VV

VS. A15A

RECEIVED
OCT 9 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH Dr Gatten 08881

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 89 Mt. Pleasant St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 89 Mt. Pleasant St.

3. NAME OF DECEASED (Type or Print): (First) ANNA (Middle) ELIZABETH (Last) WRIGHT
4. DATE OF DEATH: (Month) Sept. (Day) 12 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
female	white	widowed	4-30-1867	83 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Maryland	USA

13. FATHER'S NAME: Andrew Seifarth
14. MOTHER'S MAIDEN NAME: Elizabeth Cole

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Earl Wright, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	1 month
1442 X Antecedent cause(s) 131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) C-V-R Disease	10 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 12, 1950, to Sept. 12, 1950, that I last saw the deceased alive on Sept. 9, 1950, and that death occurred at 12⁰⁰ N. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W E Gattens	M.D.	167 E. Main St. Frostburg, Md.	Sept. 16, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-14-50	Frostburg Mem'l Park	Frostburg, Md.

DATE REC'D BY LOCAL REG. 9-16-50 — REGISTRAR'S SIGNATURE Mrs Nancy N. Lore

24. FUNERAL DIRECTOR: J. R. Durst — ADDRESS: Frostburg, Md.

RECEIVED
SEP 20 1950
BUREAU V. S